

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
surname is shown on
Film No. G99 - .11/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

CERTIFICATE OF DEATH

10339

★ Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)Street No. Route
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Lula Mac Stevenson Boston

3.(b) Social Security Number

4. Sex

female

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of
deceased (mo., day, yr.)July 26, 1945

8. AGE:

Years

2

Months

Days

It less than one day

_____ hrs.

_____ min.

9. Birthplace Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

John Boston

13. Birthplace

Somerset Co., Maryland

14. Maiden name

Helen Stevenson

15. Birthplace

Somerset Co., Md.

18. Informant

Helen Stevenson

Address

Princess Anne Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 18, 1945
(month) (day) (year)

Cemetery

Dublin Cemetery

Location

Princess Anne Md.

18. Funeral director

William James & Son

Address

Princess Anne, Md.

19. (Date rec'd by registrar)

Oct. 18, 1945

Registrar

R.H. Johnson, M.D.
Per g.d.

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 17, 1945 at 5:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Myocardium

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

R.H. Johnson

M. D. or other

Address

Princess Anne Md.Date signed 10/17/45

STATE OF CALIFORNIA

RECEIVED

OCT 19 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

Reg. Dist. No. 10340 265

1. PLACE OF DEATH:

County Somerset
 City or town Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 67 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Davis Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Minnie Belle Brown

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Hezikah Brown
 6.(c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) February 21, 1878
 8. AGE: Years 67 Months 7 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Crisfield-Somerset-Maryland
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Isaac Riggin
 13. Birthplace Crisfield, Maryland
 MOTHER 14. Maiden name Delia Hurley
 15. Birthplace Crisfield, Maryland

18. Informant Hezikah Brown
 Address Crisfield, Maryland

17. Burial Date thereof Oct. 17, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Crisfield Cemetery
 Location Crisfield, Maryland

18. Funeral director H. Harvey Bradshaw
 Address Crisfield, Maryland

19. 10/16/45 L. E. Collins, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1945 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1945 to Oct 15, 1945
 and that I last saw him alive on Oct 14, 1945

Immediate cause of death Unk. Dec 7 (heart)
Unk. Dec 7 (heart)
 Due to Dissecting aortic aneurysm
Unk. Dec 7 (heart)
 Due to Unk. Dec 7 (heart)
 Other conditions _____
 (Include pregnancy within 5 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE L. E. Collins, M.D.
 Address Mumfordsburg, Md. Date signed Oct 16 45
 M. D. or other _____

RECEIVED

OCT 27 1945

BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County Somerset
 City or town Burfield md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hrs

Hospital, institution, or street address where death occurred:

McLeod Memorial HospitalHow long in hospital or institution? 24 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Rural Promoke md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Edmond L. DeMar

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Therese E. DeMar6. (c) If alive, give age 55 years

7. Birth date of

deceased (mo., day, yr.)

April 23, 1887

8. AGE:

Years

Months

Days

If less than one day

58521

_____ hrs. _____ min.

9. Birthplace

Massachusetts
(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

FATHER
MOTHER

12. Name

John A. DeMar

13. Birthplace

Unknown

14. Maiden name

Elizabeth Whelsh

15. Birthplace

Unknown

16. Informant

Mrs Dorothy Scott

Address

Marion md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 17, 1945
(month) (day) (year)

Cemetery or crematory

Protestant Cem

Location

Rehoboth md.

18. Funeral director

Margaretta Howard

Address

Pocomoke City md.

19.

(Date recd by Registrar)

19 45Virginia P. Dawson
C. B. Callahan
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 14, 1945 at 130 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 18, 1945 to Oct 14, 1945and that I last saw him alive on Oct 14, 1945

Immediate cause of death

Acute Dec 7 Heart

DURATION

24 hrs.

Due to

Dissected Malleus

Due to

Acute Conductions5 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

George C. Callahan
M. D. or otherAddress Maryland Date signed Oct 17, 1945

RECEIVED

OCT 27 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 262

1. PLACE OF DEATH:

County SummitCity or town Rural Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SummitCity or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Menno B. Detwiler

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Sadie Detwiler

7. Birth date of deceased (mo., day, yr.)

September 17-18696. (c) If alive, give age 76 years

8. AGE:

Years 76Months 1Days 10

If less than one day

hrs. min.

9. Birthplace

Ohio
(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

Joe Detwiler

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal). Which?

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 45Mrs Clayton Davis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 19. 45, at 12:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 19. 45, to Oct 27 19. 45and that I last saw him alive on Oct 26 19. 45

Immediate cause of death

Heart died & rupt.Coronary occlusion.Due to Chronic heart failureChronic myocarditisDue to Genital arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Engel A. Williams M.D.
M. D. or otherAddress Maryland Date signed Oct 29 1945

RECEIVED
NOV 1 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 187-2

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

McCready Memorial HospitalHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Somerset

City or town..... RURAL Westover
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John Ewing Hartman

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... Salomie Smith Hartman6. (c) If alive, give age..... 69 years7. Birth date of deceased (mo., day, yr.) January 22 1876

8. AGE: Years Months Days If less than one day
69 8 9 hrs. min.

9. Birthplace..... Rockingham County, Virginia
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... George Hartman13. Birthplace..... Rockingham County, Va.14. Maiden name..... Elizabeth Beery15. Birthplace..... Rockingham County, Va.16. Informant..... Mrs. John HartmanAddress..... Westover, Md. RFD.17. Burial Date thereof..... Oct. 5, 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Quinton CemeteryLocation..... Pocomoke City RFD. #118. Funeral director..... H. Harven BradshawAddress..... Crisfield, Maryland19. Oct 5 1945 Julius P. Rawson Registrar(Date rec'd by registrar) E. E. Bellus M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 1, 1945 at 7:45A M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 15 1945 to Oct 1 1945
 and that I last saw him alive on Oct 1 1945

Immediate cause of death.....
Acute Myocardial Infarction
Chronic uremia

Due to.....

Due to.....

Other conditions..... Int. atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations..... Enlarged heart, atherosclerosis, chronic uremia, chronic bronchitis, emphysemaDate of op. Sept 29 45Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... James P. Mullen M.D.

M. D. or other

Address..... Westover, Md.Date signed..... Oct 3 45

RECEIVED
OCT 27 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 103

10344

CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH:

County Somerset
 City or town Shell Town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 1/2 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Somerset
 City or town Shell Town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Bertram Holden

3. (b) Social Security Number

213-12-3694

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Jenny Holden

7. Birth date of

deceased (mo., day, yr.)

July 14 1888

6. (c) If alive, give age

57 years

8. AGE:

Years

Months

Days

If less than one day

57314

hrs.

min.

9. Birthplace

Accomack Co Va
(Town, county, and state)

10. Usual occupation

Farming & seafood work

11. Industry or business

FATHER
MOTHER

12. Name

Major Lee Holden

13. Birthplace

Accomack Co Va

14. Maiden name

Lizzie Ann Holden

15. Birthplace

Accomack Co Va

16. Informant

Sarah Lizzie Ballen

Address

Marumaco Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Oct 31 1945
(month) (day) (year)

Cemetery or crematory

M.E. Edwards

Location

Marumaco Md

18. Funeral director

Chas H Wood

Address

Marion Md

19.

(Date rec'd by registrar)

19

10/3045Twelia B. Lawson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 25 1945 to Oct 28 1945and that I last saw him alive on Oct 27 1945Immediate cause of death Acute Dilated

DURATION

Cholera

Due to

Due to

Other conditions Cholera but rephilesCholera murebilis
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

George B. Coulburn MD

M. D. or other

Address Marumaco Md Date signed Oct 29 45

RECEIVED
NOV 1 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Gertrude H. Holland

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

John Holland

7. Birth date of deceased (mo., day, yr.)

Feb 22, 18758.(c) If alive, give age 72 years

8. AGE:

Years

Months

Days

If less than one day

70721

hrs.

min.

9. Birthplace

Marion Station, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Henry Whitehall

13. Birthplace

Marion Station, Md.

14. Maiden name

Elizabeth Whittington

15. Birthplace

Marion Station, Md.

16. Informant

Mrs. W. W. Clayton

Address

Princess Anne, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 15, 1945
(month) (day) (year)

Cemetery or crematory

Prosser Cemetery

Location

Princess Anne, Md.

18. Funeral director

Wale Washell

Address

Princess Anne, Md.

19.

(Date rec'd by registrar)

19

Oct. 15, 45
H. S. Johnson
Registrar

23. SIGNATURE

P. Smith
M. D. or other
Address Princess Anne, Md.
Date signed 10/15/45

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-13th 1945 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to 19____

and that I last saw h. _____ alive on 19____

Immediate cause of death

Arterio Sclerosis

DURATION

Due to

Due to

Other conditions

Chronic Arthritis20 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED

RECEIVED
OCT 16 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

10346

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 24 years
 Hospital, institution, or street address where death occurred:
McCready Memorial Hospital
 How long in hospital or institution?..... 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 14 Hudson Street
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Mattie Veora Hudson

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... William Hudson
 6. (c) If alive, give age..... 77 years
 7. Birth date of deceased (mo., day, yr.)..... October 22, 1894
 8. AGE: Years..... 50 Months..... 11 Days..... 12 If less than one day..... hrs. min.

9. Birthplace..... N. Wilkesboro-Wilkes-North Carolina
 (Town, county, and state)

10. Usual occupation..... House wife

11. Industry or business

FATHER 12. Name..... William A. Nichols
 13. Birthplace..... Wilkes County, North Carolina
 MOTHER 14. Maiden name..... Elvira Nichols
 15. Birthplace..... Wilkes County, North Carolina

16. Informant..... A. R. Nichols
 Address..... Princess Anne, Md.

17. Burial..... Burial Date thereof..... Oct. 6, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rehobeth Presbyterian Cem.
 Location..... Rehobeth, Maryland

18. Funeral director..... H. Harvey Bradshaw
 Address..... Crisfield, Maryland.

19. 10/6 1945 Julia B. Lawton Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 4 1945 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Oct 4 1945 and that I last saw him alive on Oct 4 1945

Immediate cause of death..... Acute Dil 7 Heart

DURATION

Due to..... Cucumonia 7 Signed Colon + Blood
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Exfoliating Lung
Oct 3 1945 Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... James A. Sullivan M. D. or other
 Address..... Baltimore Date signed..... Oct 5 1945

RECEIVED
OCT 27 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

10347



Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)Street No. Mt. Vernon
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie Hurdle

3. (b) Social Security Number

4. Sex

female

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

?

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Unknown

8. AGE:

Years

Months

Days

If less than one day

60———

hrs.

min.

9. Birthplace

?

(Town, county, and state)

10. Usual occupation

no. occupation

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. John Parks

Address

Princess Anne, Md. Rt. # 2

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 17, 1945
(month) (day) (year)

Cemetery or crematory

Alms House Cemetery

Location

Princess Anne - Mt. Vernon

18. Funeral director

James Dennis

Address

Princess Anne, Md.

19.

(Date rec'd by registrar)

Oct. 17, 1945Rt. Johnson, Md.

Registrar

Per g.d.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1945 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h.

alive on

19

Immediate cause of death

Epilepsy

DURATION

Due to

Due to

Other conditions

Cerebral Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Smith

M. D. or other

Address

Princess Anne, Md.Date signed 10/17/45

CERTIFICATE OF DEATH

RECEIVED
OCT 19 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH:

County Anne Arundel

City or town Green St. Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

see sep

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Green St. Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Armin Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race Cal 6.(a) Single, married, widowed, or divorced married

B.(b) Name of husband or wife Ira Johnson

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 30 1879

8. AGE: Years 66 Months 4 Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Green St. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Levin Fleunung

13. Birthplace Md

14. Maiden name Estine Green

15. Birthplace Md

16. Informant Ira Johnson

Address Marion Md

17. Burial Date thereof Oct 8 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church Cemetery

Location Marion Md

18. Funeral director George W. Telphman

Address Marion Md

19. 10/9 45 Armin B. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1945 at 4:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1945 to Oct 5 1945 and that I last saw her alive on Oct 5 1945.

Immediate cause of death Arteriosclerotic heart disease DURATION 1 week
Due to Chronic lat. vegetals 3 years
Chronic nephritis
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE George W. Telphman M. D. or other _____
Address Marion St. Md Date signed Oct 6 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 11 1945
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 10349 270

1. PLACE OF DEATH:

County..... **Somerset**
 City or town..... **RURAL, Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **72 years**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Somerset**
 City or town..... **RURAL, Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **# Rt. 2**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Benjamin F. Johnson

3. (b) Social Security Number

4. Sex..... **Male** 5. Color or race..... **White** 6.(a) Single, married, widowed, or divorced..... **Married**
 6.(b) Name of husband or wife..... **Mary Horsey Johnson**
 6.(c) If alive, give age..... **66** years
 7. Birth date of deceased (mo., day, yr.)..... **October 9, 1873**
 8. AGE: Years..... **72** Months..... **0** Days..... **7** If less than one day..... hrs. min.

9. Birthplace..... **Marion-Somerset-Maryland**
 (Town, county, and state)

10. Usual occupation..... **Farmer**11. Industry or business..... **Truck farms**12. Name..... **Samuel Johnson**13. Birthplace..... **Marion, Maryland**14. Maiden name..... **Mary Anne Boston**15. Birthplace..... **Marion, Maryland**16. Informant..... **Mrs. Benjamin Johnson**Address..... **Crisfield, Md. # Rt2**

17. Burial, cremation, or removal. Which?..... **Burial** Date thereof..... **Oct. 19, 1945**
 (month) (day) (year)

Cemetery or crematory..... **Sunny Ridge Cemetery**Location..... **Crisfield, Md. # Rt. 2**18. Funeral director..... **H. Harvey Bradshaw**Address..... **Crisfield, Maryland**

19. **10/19/45** **C. E. Collins**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Oct 12 1945** at **11:15 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Oct 12 1945** to **Oct 16 1945** and that I last saw him alive on **Oct 15 1945**

Immediate cause of death.....

Cerebral hemorrhage -
arteriosclerotic
hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

S. M. Panton M.D.

M. D. or other

Address..... **Crisfield, Md.** Date signed..... **Oct 18, 1945**

RECEIVED

OCT 27 1945

BUREAU V. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

CERTIFICATE OF DEATH

10350

Reg. Dist. No. 760

1. PLACE OF DEATH

County SomersetCity or town Westover R.F.D.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life Time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Westover
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Rosie Jones

3. (b) Social Security Number

4. Sex Fr. 5. Color or race Colored 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Andrew Jones7. Birth date of deceased (mo., day, yr.) November, 6, 1895 6.(c) If alive, give age Not known8. AGE: Years 49 Months 9 Days 26 If less than one day _____ hrs. _____ min.9. Birthplace Somerset Co.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Jessie Priel13. Birthplace Somerset County14. Maiden name Jessie Pitts15. Birthplace Somerset County16. Informant Andrew JonesAddress Westover, Md.17. Burial Date thereof 10/7/1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Revell neck, Md.Location Revell neck, Md.18. Funeral director William H. James Jr.Address Princess Anne, Md.19. Oct 6 45 R. J. James Jr.
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 3 19 45 at 7:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 19 45 to Oct 3 19 45and that I last saw her alive on Oct 3 19 45Immediate cause of death central hemorrhage

DURATION

1 day

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank M. Jones M. D. or otherAddress Princess Anne Date signed Oct 4 1945

RECEIVED
OCT 9 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

10351

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 42 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Broadway
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Versie Jones

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Samuel Purnell Jones
 7. Birth date of deceased (mo., day, yr.)..... 1903 6.(c) If alive, give age..... years
 8. AGE: Years..... 42 Months..... ? Days..... ? If less than one day..... hrs. min.

8. Birthplace..... Crisfield-Somerset-Maryland
 (Town, county, and state)
 10. Usual occupation..... Crab Picker
 11. Industry or business..... Sea Food Plant
 12. Name..... William H. Jones
 13. Birthplace..... Pocomoke City, Md
 14. Maiden name..... Kathryn Sterling
 15. Birthplace..... Crisfield, Maryland
 16. Informant..... Mary Jones
 Address..... Crisfield, Maryland
 17. Burial Date thereof..... Oct. 6, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Lawsonia Cemetery
 Location..... Crisfield, Maryland
 18. Funeral director..... H. Harvey Bradshaw
 Address..... Crisfield, Maryland

19. 10/6/45 19..... E. E. Gallows M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 2 19..... 45 at..... 10:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 2 19..... 45, to..... Oct 2 19..... 45
 and that I last saw her..... alive on..... Sept 19..... 45
 Immediate cause of death.....
cardiovascular

DURATION..... 3 hrs.
 Due to..... Brucella..... 15 yr.
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... E. E. Gallows M.D. M. D. or other
 Address..... Crisfield, Md Date signed..... Oct 6, 1945

RECEIVED
OCT 12 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

10352

Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Wallace Raymond Long4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Lena M. Long7. Birth date of deceased (mo., day, yr.) Dec. 10 1877 6. (c) If alive, give age 69 years8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Somerset County
(Town, county, and state)10. Usual occupation merchant

11. Industry or business

12. Name Santa Long13. Birthplace Somerset County14. Maiden name Mary A. King15. Birthplace Somerset County16. Informant Vernon LongAddress Princess Anne Md.17. Burial Date thereof Oct 22 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Episcopal CemeteryLocation Princess Anne Md.19. Funeral director Dale DashedAddress Princess Anne Md.19. Oct 23 45 R. H. Johnson, M.D.
(Date rec'd by registrar) RegistrarPer g.d.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 48 19 48 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him alive on 19 48Immediate cause of death Cerebral Hemorrhage DURATION 10 days

Due to _____

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Smith M. D. or other _____Address Princess Anne Md. Date signed 10/22/48

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

OCT 24 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

CERTIFICATE OF DEATH

Reg. Dist. No. 10353 265

1. PLACE OF DEATH:

County Somerset
 City or town Berksfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Somerset
 City or town Berksfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1st St
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Benjamin S. Mills Jr.
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

214-03-5767

MEDICAL CERTIFICATION

6.(b) Name of husband or wife Elizabeth S. Mills
 7. Birth date of deceased (mo., day, yr.) Sept. 13, 1901
 8.(c) If alive, give age 46 years

8. AGE: Years 44 Months 21 Days hrs. min.

9. Birthplace Berksfield MD
 (Town, county, and state)

10. Usual occupation Railroad laborer

11. Industry or business Pen. RR.

12. Name Benjamin S. Mills Jr.

13. Birthplace Berksfield, Md Va

14. Maiden name Uddie Messick

15. Birthplace Va

16. Informant Elizabeth S. Mills

Address Berksfield MD

17. Burial Date thereof 10/8/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sunny Ridge

Location Berksfield MD

18. Funeral director Howard H. Hubbard

Address 306 Main St Berksfield, MD

10/5/45 19. (Date rec'd by registrar)

C. E. Collins, M.D. Registrar

20. DATE OF DEATH Oct 4 19 45 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 44 to Oct 4 19 45 and that I last saw him alive on Oct 4 19 45

Immediate cause of death Agente dilatation

of Pericardium DURATION 3 days

Due to Chronic Myo-

carditis 18 mo

Other conditions Cirrhosis of liver
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Collins

M. D. or other

Address Berksfield Date signed 10-5-45

RECEIVED TO THE SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED
OCT 27 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10354



Reg. Dist. No. 27 260

1. PLACE OF DEATH:

County Somerset
 City or town Camp Somerset, Westover, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Year 1 Mo. (18 Sep. 45)
 Hospital, institution, or street address where death occurred: Station Disp. Camp Somerset, Westover, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County
 City or town Allentown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 736 N. 7th Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

ROBERT R. MOYER, Sgt, 33488371, Hq & Hq Det, CMP

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elsie A. Moyer

7. Birth date of deceased (mo., day, yr.) Jan 12 1921 6.(c) If alive, give age years

8. AGE: Years 24 Months 9 Days 7 If less than one day hrs. min.

9. Birthplace Unknown
 (Town, county, and state)

10. Usual occupation Soldier11. Industry or business U S Army12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Service RecordAddress U S Army

17. Removal Date thereof 10/20/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory J S BurkholderLocation 1601 Hamilton St Allentown Pa18. Funeral director Howard N. Bliglet Jr.Address 4914 Belair Road19. 20 Oct 19 45 Frank J. Tellison Registrar(Date rec'd by registrar) Capt, MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Oct. 19 45 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Oct. 19 45 to 18 Oct. 19 45 in im alive on 18 Oct. 19 45

Immediate cause of death Reaction, Anaphylactic, severe with Respiratory and cardiac failure
 Due to Influenza virus vaccine types A&B.

xxx (County Coroner notified)

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G-L Sagone M.D. or otherAddress A.L.SAGONE, Major, MC Cp Somerset, Westover, Md. Date signed 19 Oct 45

RECEIVED
OCT 25 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

10355

Reg. Dist. No. 268

1. PLACE OF DEATH:		Somerset		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County.....		Chance		(For newborn infants give residence of mother)	
City or town.....		(If outside city or town limits, write RURAL and give nearest town)		State..... Md County..... Somerset	
How long in above place of death?.....		83-9-9		City or town..... Chance	
Hospital, institution, or street address where death occurred:				(If outside city or town limits, write RURAL and give nearest town)	
How long in hospital or institution?.....				Street No.....	
				(If rural, give LOCATION)	
3. (a) FULL NAME				3. (b) Social Security Number	
Mary Ella Price					
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced			
Female	White	Married			
B. (b) Name of husband or wife		Jerome Price			
7. Birth date of deceased (mo., day, yr.)		B. (c) If alive, give age..... 86 years			
Jan 5 1883 1862					
8. AGE:	Years	Months	Days	If less than one day	
83	9	9	hrs. min.		
9. Birthplace..... Chance Somerset Maryland					
(Town, county, and state)					
10. Usual occupation..... housewife					
11. Industry or business					
12. Name..... Robert Hickman					
13. Birthplace..... ? Va					
14. Maiden name..... Clemen Jones					
15. Birthplace..... Chance Md					
16. Informant..... Thomas Price					
Address..... Chance Md					
17. Burial Date thereof..... Oct 16 1945					
(Burial, cremation, or removal. Which?) (month) (day) (year)					
Cemetery or crematory..... Rock Creek Cemetery					
Location..... Chance Md					
18. Funeral director..... John A Bradsnaw					
Address..... Crisfield Md					
19. (Date rec'd by registrar)..... Oct 16 1945 - Rosa Velez					
Registrar					
MEDICAL CERTIFICATION					
20. DATE OF DEATH..... Oct 14 1945 at 9:00 AM					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....					
and that I last saw h..... alive on..... 19.....					
Immediate cause of death..... Arteriosclerosis					
Due to..... Myocarditis					
Due to.....					
Other conditions.....					
(Include pregnancy within 8 months of death)					
Major findings of operations.....					
Date of op.....					
Autopsy results.....					
PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following:					
Accident, suicide, or homicide..... Date of.....					
Where did injury occur?..... (City or town) (County) (State)					
Injured at home, farm, industry, public place (where?).....					
Means of injury..... Injured at work?					
23. SIGNATURE..... J. J. Smith					
M. D. or other					
Address..... Primus Ann Md Date signed..... 10/15/45					

RECEIVED
OCT 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore [216]

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County... **Somerset**
 City or town... **Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **11 days**
 Hospital, institution, or street address where death occurred:
McCready Hospital
 How long in hospital or institution? **11 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Maryland** County... **Somerset**
 City or town... **RURAL, Pocomoke City**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **# Rt. 1**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Iona Tilghman

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Widowed**
 6.(b) Name of husband or wife **John H. Tilghman**
 7. Birth date of deceased (mo., day, yr.) **January 24, 1871** 6.(c) If alive, give age..... years
 8. AGE: Years **74** Months **8** Days **27** If less than one day..... hrs. min.

9. Birthplace **Somerset County-Maryland**
 (Town, county, and state)

10. Usual occupation **House wife**

11. Industry or business

12. Name **Samuel Wooster**
 13. Birthplace **Moorestown, New Jersey**

14. Maiden name **Emma Dryden**
 15. Birthplace **Somerset County, Maryland**

16. Informant **James R. Tilghman**
 Address **Pocomoke City, Maryland**

17. **Burial** Date thereof **Oct. 23, 1945**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Rehobeth Presbyterian Cem.**
 Location **Rehobeth, Maryland**

18. Funeral director **H. Harvey Bradshaw**
 Address **Pocomoke City, Maryland**

19. **1943** **45** **Quella B. Tawney**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 21, 1945** at **10:00 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **October 1, 1945** to **October 21, 1945**

and that I last saw him alive on **Oct 21, 1945**

Immediate cause of death **Acute Dilat. Heart**
failure

Due to **acute dilat. heart**
 Due to **acute myocardial**

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE **George B. Chace**
 M. D. or other
 Address **Frederick, Md.** Date signed **Oct 22-45**

RECEIVED

NOV 15 1945

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-2

CERTIFICATE OF DEATH

10357

Reg. Dist. No. 260

1. PLACE OF DEATH: Somerset
County.....
City or town..... Eden md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... md County..... Somerset
City or town..... Eden md
(If outside city or town limits, write RURAL and give nearest town)
Street No..... no
(If rural, give LOCATION)
2.(a) If veteran, name war..... World War No. 2

3.(a) FULL NAME
Monroe J. Turner

3. (b) Social Security Number
214-12-6807

4. Sex..... male 5. Color or race..... a a 6.(a) Single, married, widowed, or divorced..... Single
6.(b) Name of husband or wife..... no
7. Birth date of deceased (mo., day, yr.)..... Oct 6 1907
8. AGE: Years..... 41 Months..... - Days..... - If less than one day..... hrs. min.

9. Birthplace..... Eden md
(Town, county, and state)

10. Usual occupation..... Soldier World War No. 2

11. Industry or business..... Farmer

12. Name..... Rufus Turner

13. Birthplace..... Printers Anne md

14. Maiden name..... Dollie Barkley

15. Birthplace..... Eden md

16. Informant..... Mrs. Dollie Turner

Address..... Eden md

17. Burial Date thereof..... Oct 7 45
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory..... Flower Hill md

Location..... Eden md

18. Funeral director..... James H. Stewart

Address..... Salisbury

19. Oct 6, 45 R. H. Johnson M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 10-5 1945 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-4 1945 to 10-5 1945

and that I last saw him alive on 9-4-1945

Immediate cause of death..... Respiratory Paralysis DURATION

Due to..... Cerebral destruction

Due to..... Old cerebral injury

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Antopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE..... E. Purnell M.D.
M. D. or other

Address..... 800 W. Main ST. Date signed..... 10-8-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-2)

CERTIFICATE OF DEATH

★ 10358 261
Reg. Dist. No.

1. PLACE OF DEATH:

County Somerset
City or town Marion Station
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Somerset
City or town Marion Station
(if outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war None

3. (a) FULL NAME

Samuel Thomas Ward

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) Sept. 21 1860 8. (c) If alive, give age..... years

8. AGE: Years 85 Months 16 Days 16 If less than one day..... hrs. min.

9. Birthplace Somerset Co. MD
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Buy

12. Name Walter B. Ward

13. Birthplace Somerset Co. MD

14. Maiden name Reah Ward

15. Birthplace Somerset Co. MD

16. Informant Belle W. Hall

Address Marion Station MD

17. Burial Date thereof 10/9/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls

Location Marion Station MD

18. Funeral director Howard J. Huller

Address 306 Main St. Springfield MD

19. 10/9 1945 Paula P. Larson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945 at 10³⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Oct 7 1945 and that I last saw him alive on Oct 5 1945

Immediate cause of death Acute Dilat. Heart Failure
DURATION 1 week

Due to.....

Due to Chronic Dilat. irregular
course myocardial
DURATION years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paula P. Larson M. D. or other

Address Marion St. MD Date signed Oct 45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILE NO. 100-100000-100000

RECEIVED
OCT 19 1945
BUREAU V.R.

RECEIVED OCT 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-)

CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH:

County Somerset
City or town Wrentham, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
City or town Wrentham
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Perry White

3. (b) Social Security Number

4. Sex Male 5. Color or race White (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna White

7. Birth date of deceased (mo., day, yr.) Feb 14th 1880 6. (c) If alive, give age 65 years

8. AGE: Years 65 Months 8 Days 14 If less than one day hrs. min.

9. Birthplace Wrentham (Town, county, and state)

10. Usual occupation Oystererman

11. Industry or business Wm. E. White

12. Name Wm. E. White

13. Birthplace Wrentham, Md.

14. Maiden name Anna White

15. Birthplace Wrentham, Md.

16. Informant Ray Phillips White

Address Salisbury, Md.

17. (Burial, cremation, or removal) Burial Date thereof Oct. 29-45 (month) (day) (year)

Cemetery or crematory St. Paul's M. E.

Location Wrentham, Md.

19. Funeral director Dr. G. E. Johnson

Address Dr. G. E. Johnson

19. (Date rec'd by registrar) Oct 29-45 Rosa Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-26-45 at 12.2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Tuberculosis

DURATION 12 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE R. Smith M.D. M. D. or other

Address Primer, Ann, Md. Date signed 10/29-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

ALFRED W. BROWN, JR.

RECEIVED
NOV 7 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFAADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 103810

1. PLACE OF DEATH:

County DorchesterCity or town Mt. Vernon, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County DorchesterCity or town Mt. Vernon Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Agness Williams

3. (b) Social Security Number

4. Sex F 5. Color or race B 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife William Williams

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Unknown 19038. AGE: Years 42 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Edenton North Carolina
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown

13. Birthplace _____

14. Maiden name Unknown

15. Birthplace _____

16. Informant Rushia BaileyAddress Mt Vernon, Md.17. Burial Date thereof Oct. 31, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Paul CemeteryLocation Mt. Vernon, Md.19. Funeral director Wale WashfieldAddress Princess Anne, Md.18. Oct. 31, 1945 R.H. Johnson, Md.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29th 1945 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 6th 1945 to Oct 29th 1945and that I last saw her alive on Oct 27th 1945

Immediate cause of death

Cerebral HaemorrhageDue to Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. G. M. DavisAddress Princess Anne, Md. M. D. or other _____Date signed 10.31.45

CERTIFICATE OF DEATH

RECEIVED
NOV 1 1945
BUREAU V.R.